LUMENOS HEALTH SAVINGS ACCOUNT

This schedule generally describes the benefits available for Covered Services under this Summary Booklet. For a more detailed explanation of benefits provided, you should refer to the appropriate section of the Summary Booklet. This Schedule of Benefits is subject to all the terms, conditions, and limitations set forth in this Summary Booklet.

COVERED SERVICE	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Covered Person Plan Year Deductible	$1,500 single * $3,000family **	
Covered Person Coinsurance	Not Applicable	20%
Covered Person Plan Year Out-of-Pocket Limit * Applies to Prescription Drug Copayments	$1,500 single*** $3,000 family****	$4,000 single*** $8,000 family****
Lifetime Maximum	Unlimited	Unlimited

***Single Deductible** –The Deductible must be satisfied before any Covered Services are paid by the Plan except for Preventive Services which are not subject to the Deductible.

****Family Deductible** – The family Deductible must be satisfied before any Covered Services are paid by the plan except for Preventive Services which are not subject to the Deductible. The family Deductible may be satisfied by one Covered Person or all members of the family collectively.

*****Single Out-of-Pocket Limit** – Once the Member Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Covered Person for the remainder of the benefit period except for Out-of-Network Human Organ and Tissue Transplant services.

******Family Out-of-Pocket Limit** – Once the family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Family for the remainder of the benefit period except for Out-of-Network Human Organ and Tissue Transplant services.

In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not accumulate toward each other.

PREVENTIVE SERVICES		
Well Child Care	No Cost-Share	Deductible & Coinsurance
Adult Physical Examinations	No Cost-Share	Deductible & Coinsurance

Other Preventive screenings including but not limited to: Routine gynecological care: pap smear and pelvic exam, Prostate screening, Mammography screening, colorectal cancer screening, flexible sigmoidoscopy, colonoscopy, total cholesterol screening, lipid screenings and panels, diabetic screening (See Preventive Services in the Covered Services section for additional information)	No Cost-Share	Deductible & Coinsurance
Immunizations and Vaccinations (Other than those needed for travel, see OTHER MEDICAL SERVICES section of the Schedule of Benefits)	No Cost-Share	Deductible & Coinsurance
HOSPITAL SERVICES		
All Inpatient Admissions	Deductible	Deductible & Coinsurance
Specialty Hospital 100 days per Member per Calendar Year	Deductible	Deductible & Coinsurance
Outpatient Surgery (Including colonoscopy) Note: See Other Medical Services section also, for Outpatient Surgery rendered in an ambulatory surgical center	Deductible	Deductible & Coinsurance
DIAGNOSTIC SERVICES		
Diagnostic, Laboratory and X-ray Services	Deductible	Deductible & Coinsurance
High Cost Diagnostic Tests MRI, MRA, CAT, CTA, PET, and SPECT scans	Deductible	Deductible & Coinsurance
THERAPY SERVICES		
Outpatient Rehabilitation Outpatient rehabilitative and restorative physical, occupational, speech and chiropractic therapy for up to 60 combined visits per Calendar Year	Deductible	Deductible & Coinsurance
Other Therapy Services: Outpatient cardiac rehabilitation therapy Radiation therapy: Chemotherapy for the treatment of cancer Electroshock Therapy Kidney Dialysis in a Hospital or free-standing dialysis center	Deductible	Deductible & Coinsurance
Allergy Office Visit/Testing **Allergy Injections** Immunotherapy or other therapy treatments	Deductible Deductible	Deductible & Coinsurance Deductible & Coinsurance
MEDICAL EMERGENCY / URGENT CARE SERVICES		

Emergency Room Treatment Emergency Room Cost-Share waived if the Member is admitted directly to the Hospital from the emergency room **Urgent Care Services**	Deductible Deductible	Deductible Paid as In-Network Emergency Room
Ambulance Land & Air: Paid according to the Department of Public Health Ambulance Service Rate Schedule	Deductible	Deductible
PHYSICIAN MEDICAL/ SURGICAL SERVICES		
Medical Office Visit	Deductible	Deductible & Coinsurance
Surgical Services Performed by a Surgeon or Physician (Specialist) in any setting other than an Office Visit	Deductible	Deductible & Coinsurance
Non-Surgical Services of a Physician or Surgeon (Other than a medical office visit) These services may include after care or attending medical care	Deductible	Deductible & Coinsurance
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
Outpatient Treatment for Mental Health Care and Substance Abuse Care **Inpatient Hospital Services** In a Hospital or Residential Treatment Center for Mental Health Care **Inpatient Rehabilitation Treatment for Substance Abuse Care** In a Hospital or Substance Abuse Treatment Facility	Deductible Deductible Deductible	Deductible & Coinsurance Deductible & Coinsurance Deductible & Coinsurance
OTHER MEDICAL SERVICES		
Outpatient Surgery In a licensed ambulatory surgical center (not located in a Hospital setting) (including colonoscopy) Note: See the Hospital Services section also for Outpatient Surgery rendered in a Hospital setting.	Deductible	Deductible & Coinsurance
Skilled Nursing Facility Up to 120 days per Calendar Year	Deductible	Deductible & Coinsurance
Immunizations and Vaccinations for Travel	Deductible	Deductible & Coinsurance

Prescription Drugs: **Retail Pharmacy:** The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 30 day supply. Diabetic equipment, drugs and supplies **Specialty Pharmacy** The maximum supply of a Specialty Drug for which benefits will be provided when dispensed under any one prescription is a 30 day supply. **Mail Order Prescription Drug Program** The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is a 1-90-day supply. Diabetic drugs and supplies	Deductible & then: Tier 1 $10 Copay per Covered Drug Tier 2 $25 Copay per Covered Drug Tier 3 $40 Copay per Covered Drug Tier 1 $10 Copay per Covered Drug Tier 2 $25 Copay per Covered Drug Tier 3 $40 Copay per Covered Drug Tier 1 $10 Copay per Covered Drug Tier 2 $50 Copay per Covered Drug Tier 3 $80 Copay per Covered Drug	Deductible & Coinsurance per prescription Deductible & Coinsurance per prescription Deductible & Coinsurance per prescription
Human Organ and Tissue Transplant Services Unlimited maximum	Deductible	Deductible & Coinsurance
Home Health Care (Including In-Home Hospice Care) Nursing and therapeutic services limited to 200visits **In the Home Hospice Medical Social Services** under the direction of a Physician Up to $420.	Deductible Deductible	Deductible & Coinsurance Deductible & Coinsurance
Infusion Therapy Unlimited lifetime maximum	Deductible	Deductible & Coinsurance
Durable Medical Equipment and Prosthetic Devices **Hearing Aid Coverage** Available for dependent children age 12 years and under **Diabetic equipment, and supplies**	Deductible	Deductible & 50% Coinsurance
Ostomy Related Services	Deductible	Deductible & 50% Coinsurance
Hospice Care (inpatient)	Deductible	Deductible & Coinsurance
Wig Up to $500 maximum per Member per Calendar Year.	Deductible	Deductible & Coinsurance
Specialized Formula	Deductible	Deductible & Coinsurance

Infertility Services Please see Maternity/Family Planning Section of this document		
Office Visit	Deductible	Deductible & Coinsurance
Outpatient Hospital	Same as Hospital Outpatient Cost-Share	Deductible & Coinsurance
Inpatient Hospital	Same as Hospital Inpatient Cost-Share	Deductible & Coinsurance
Infertility Drugs The maximum supply of a drug for which benefits will be provided when dispensed under any one prescription is 30 day supply	Deductible	Deductible & Coinsurance
Maternity	Deductible	Deductible & Coinsurance

Pre-Existing Condition Limitation Exclusion – For Late Enrollees, this Summary Booklet does not cover charges for Pre-Existing Conditions diagnosed or treated during the 6 months immediately preceding the original Effective Date of continuous coverage during the Pre-Existing Condition Limitation Period. The Pre-Existing Condition Limitation Period may last up to 12 months from your Enrollment Date. Credit from prior Creditable Coverage will be applied if applicable to reduce your specific Pre-Existing Condition Limitation Period. You will be notified in writing by Anthem BCBS exactly how many months you will be subject to this exclusion.

Note: Out of Network services applicable after Deductible and Coinsurance. Covered Person is responsible for the difference between Maximum Allowable Amount (MAA) and total charge.